California State Senate

COMMITTEE
ON
BUDGET AND FISCAL REVIEW

ROOM 5019, STATE CAPITOL
SACRAMENTO, CA 95814

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Agenda
May 30, 2008
10 a.m. - Room 4203

HEALTH

DISCUSSION AGENDA

Pursuant to the Americans with Disabilities Act, individuals who, because of a disability, need special assistance to attend or participate in a Senate Committee hearing, or in connection with other Senate services, may request assistance at the Senate Rules Committee, 1020 N Street, Suite 255 or by calling 916-324-9335. Requests should be made one week in advance whenever possible.

Program Description	Comments

8955-301-0001 and 8955-496 Department of Veterans Affairs

Combine and Augment Barstow Emergency Generator and Improve Kitchen Cooling System projects. The Department of Veterans Affairs (CDVA) requests: (1) reversion of unexpended funding provided in the Budget Act of 2007 for working drawings and construction of an Emergency Generator and a Kitchen Cooling System at the Veterans Home of California-Barstow (Barstow); and (2) an $89,000 General Fund augmentation to address unanticipated costs for the aforementioned projects.	The Fiscal Year 2007-08 requests for each of these projects were based on rough estimates by the CDVA; however, a subsequent and more thorough set of estimates, put together by the Department of General Services, resulted in this request for additional resources. Staff notes that this request is due in part to unanticipated increases in the costs of copper and steel. The CDVA indicates that combining the two projects will result in administrative cost avoidance of approximately $15,000. Staff Recommendation: Approve the request.

Program Description	Comments

4260--Various Department of Health Care Services—Vote Only Items

May Revision *Baseline* Caseload Adjustment and Cost Changes & Adjustment to Special Session AB X3 5 Actions in the Medi-Cal Program (May Revise) (DOF issues #600, #279 and #283) In the May Revision, the Administration is proposing several adjustments to (1) account for *baseline* changes in Medi-Cal caseload and costs that are applicable across the program, including medical assistance, administration and non-budget act items; (2) adjustments to the actions contained in Chapter 3, Statutes of 2008 (AB X3 5), to reflect additional savings; and (3) an accounting of the differences between the Governor's January proposals and actions taken in Special Session.. Specifically, a *net* increase of $512.6 million ($108.7 million General Fund) is proposed for these technical adjustments. Most of the adjustments pertain to federal funds and special funds.	Staff Recommendation: It is recommended to approve these technical adjustments. These May Revision issues reflect (1) standard adjustments to the *baseline* Medi-Cal Program estimate for 2008-09; (2) technical fiscal updates to actions contained in prior legislation as noted; and (3) an accounting of the differences between the Governor's January proposals and actions taken in Special Session. Specifically, the May Revision reflects (1) an increase of $340 million ($22.374 million General Fund) for baseline caseload and technical cost changes; (2) a reduction of $88.2 million ($44.1 million General Fund) for adjustments to Special Session actions; and (3) an increase of $260.9 million ($130.4 million General Fund) with regards to the Governor's January proposals and actions taken in Special Session. No issues have been raised. This action is necessary to re-bench the estimate to reflect the May Revision changes and for accurate budget adjustments to be reflected.

Program Description	Comments
May Revision Adjustment for Adult Day Health Care in Medi-Cal Program (May Revise) (DOF issue #260). In the May Revision, the DHCS is requesting an increase of $18.5 million ($9.2 million General Fund) for Adult Day Health Care services provided in the Medi-Cal Program to reflect increased costs due to an estimated increase of 3,600 users and an estimated savings of $20.3 million ($10.1 million General Fund) due to the implementation of reforms that will tighten medical necessity criteria within the program.	Staff Recommendation: It is recommended to approve the technical adjustments as contained in the May Revision. The Adult Day Health Care Program reforms were discussed in Subcommittee and adopted as proposed by the DHCS. The May Revision makes technical updates, primarily to reflect an estimated increase in enrollees to the program. No issues have been raised.

Program Description	Comments
May Revision Trailer Bill Language to Clarify Adult Day Health Care in Medi-Cal Program (May Revise) The DHCS is proposing trailer bill language to technically clarify that individuals with developmental disabilities who live in Intermediate Care Facilities (ICF-DD-H and ICF-DD-N) are eligible for participation in the Adult Day Health Care (ADHC) Program in the Medi-Cal Program. The Administration states this needs to be clarified because the DHCS has unintentionally denied treatment authorization requests for ADHC services for individuals with developmental disabilities living in ICF-DD-H and ICF-DD-N facilities. With the denial of the Medi-Cal funded ADHC services that receive federal financial participation for 50 percent of the cost, the Department of Developmental Services (DDS) must fund these ADHC services at 100 percent General Fund cost. Therefore, the Administration is seeking to clarify existing statute.	Staff Recommendation: It is recommended to adopt as placeholder the Administration's clarifying language to ensure that individuals residing in ICF-DD-H and ICF-DD-N facilities are eligible for ADHC services. No General Fund costs or savings are assumed by this proposal but it does serve as a cost-avoidance.

Program Description	Comments
May Revision Adjustment for Fiscal Intermediary—Additional Pharmacy Consultants for Medi-Cal Program **(May Revise)** (DOF issue #262). In the May Revision, the DHCS is requesting an increase of $1.8 million ($324,000 General Fund) to support nine Pharmacy Consultants (under contract through the Fiscal Intermediary) to address the backlog of Treatment Authorization Requests (TARs) within the Medi-Cal Program. According to the DHCS, the current TAR workload has grown to the point where Medi-Cal has experienced a backlog in ten of the past twelve months, reaching a peak of over 32,000 TARs and a delay of up to 10 business days. Current law requires a one-day turnaround for TARs. Due to the backlog, auto-adjudication is utilized to expedite processing. The DHCS indicates that auto-adjudication has resulted in approving $6.4 million ($3.2 million General Fund) in TARs that would have been denied under more detailed review by consultants between February 2007 and March 2008. The Medi-Cal May Revision estimate projects annual savings from these nine Pharmacy Consultants of $4.7 million ($2.3 million General Fund).	Staff Recommendation: It is recommended to approve the May Revision. No issues have been raised. The proposal is cost-beneficial.

Program Description	Comments
May Revision Adjustment for Substance Abuse Screening & Brief Intervention in Medi-Cal (May Revise) (DOF issue #263) In the May Revision the DHCS proposes an increase of $1.6 million ($800,000 General Fund) to the Medi-Cal Program to add new reimbursement codes to allow medical providers to routinely screen Medi-Cal patients suspected of non-dependent substance abuse, and provide appropriate intervention services to those patients determined to be at risk of progressing towards drug or alcohol dependency. It is the intent of the DHCS to decrease utilization of more expensive programs specifically targeted to those patients with advanced alcohol and drug dependency. However, no specific information has been provided as to how this would occur. No savings have been linked to this proposal, only expenditures.	Staff Recommendation: It is recommended to deny this request due to the fiscal crisis. The Administration is proposing to make reductions in existing programs that provide focused drug and alcohol treatment. Therefore it does not make sound policy sense to commence with a new program within Medi-Cal at the May Revision when existing treatment programs are not being funded. Further, no cost-benefit or savings were identified with this proposal.

Program Description	Comments
May Revision Adjustment to the Interim Rate Payment Process for Public Hospitals in Medi-Cal (May Revise) (DOF issue #501) Under California's Hospital Financing Waiver, designated Public Hospitals are paid an interim Medi-Cal rate funded through matching the Public Hospitals "certified public expenditures" (CPEs) with federal funds. No state General Fund support is used for this payment. However, under the Medi-Cal Program, the DHCS is currently paying this interim rate as it does any other Medi-Cal hospital expenditure using 50 percent General Fund support to draw the 50 percent federal funding. As such, an accounting adjustment must be done after the fact to reflect the 100 percent federal payment. In the May Revision, the Administration is requiring the Fiscal Intermediary to implement a system change to adjust these particular Medi-Cal payments to reflect a 100 percent federal fund payment. As such, due to this new interim rate payment process for Public Hospitals, a fund shift will occur that increases by $101.862 million federal funds and decreases by $102.7 million General Fund support.	Staff Recommendation: It is recommended to adopt the May Revision adjustment as proposed to rectify the accounting for the interim rate payment made to designated Public Hospitals under the Hospital Financing Waiver.

Program Description	Comments
Child Health and Disability Prevention Program (May Revise) The May Revision for the CHDP contains minor caseload and technical fiscal adjustments. It proposes total expenditures of $2.4 million ($2.4 million General Fund) for 2008-09 which reflects a decrease of $264,000 ($251,000 General Fund) as compared to January.	Staff Recommendation: It is recommended to adopt the May Revision for caseload and all technical fiscal adjustments. The Subcommittee has previously adopted the Governor's 10 percent reduction to case management and discussions regarding rate reimbursement adjustments are discussed in the Agenda under Item 4260-111-0001, Family Health rates.

Program Description	Comments
State Support Related Functions—Remaining Governor's Budget Balancing Reductions (January) The Governor proposed numerous budget balancing reductions for the DHCS regarding State Support-related functions, including the following items: • Reduce 1 position for policy in the Breast & Cervical Treatment Program (BBR binder page 202) for savings of $74,000 ($37,000 General Fund); • Reduce 2 positions for other components of the Breast & Cervical Treatment Program (BBR binder page 204) for savings of $365,000 ($264,000 General Fund); • Reduce consultant contract for Navigant (BBR binder page 210) for savings of $720,000 ($360,000 General Fund); • Reduce 3 positions in the Provider Rate Branch (BBR binder page 214) for savings of $322,0000 ($161,000 General Fund); • Reduce Waiver Analysis Section for a reduction of $180,000 ($90,000 General Fund) (BBR binder page 216); and • Reduce contract staff in Management Services for Decision Support Systems for a reduction of $135,000 ($48,000 General Fund). Any technical May Revision adjustments are assumed to be included in this action to appropriately reflect General Fund support and federal funds.	Staff Recommendation: Due to the fiscal crisis, it is recommended to approve the Governor's reductions.

4265 Department of Public Health—Vote Only

Program Description	Comments

4265-Various Department of Public Health—Vote Only

May Revision—Genetic Disease Screening Program In the May Revision, the DPH is proposing a reduction of $2.159 million (Genetic Disease Testing Fund) in the Genetic Disease Screening Program. This technical adjustment corrects for the erroneous application of the price increase factor to certain operating expenses and equipment within the caseload-related expenditures associated with the Newborn Screening and Prenatal Screening programs.	Staff Recommendation: It is recommended to approve the May Revision. No issues have been raised.

Program Description	Comments
Proposed Fund for Biomonitoring Program The DPH budget contains an appropriation of $1.025 million General Fund to continue the five-year phase-in of Senate Bill 1379 (Perata), Statutes of 2006. This legislation established a comprehensive CA Environmental Contaminant Biomonitoring Program (Biomonitoring Program) within the DPH. When fully implemented the Biomonitoring Program will do the following: • Systematically collect, analyze, and archive blood and other human biological specimens from a statistically valid, representative sample of California's population; • Mesh with existing federal Centers for Disease Control (CDC) Biomonitoring program; and • Create a reliable database to be used as a foundation for future health-based scientific research. The Biomonitoring Program will provide data allowing state scientists and regulators to evaluate existing environmental programs, identify and prioritize emerging environmental health issues, and provide a solid scientific basis for future policy and budgetary decisions.	Staff Recommendation: Due to the fiscal crisis, it is recommended to (1) delete the $1.025 million General Fund appropriation from the DPH; (2) Increase by $1.025 million Toxic Substance Control Account to fund the Biomonitoring Program; and (3) adopt placeholder trailer bill language to enable the DPH to utilize this special fund. This fund shift is proposed by staff in order to save $1.025 million in General Fund resources. The Toxic Substance Control Account within the Department of Toxic and Substances Control has a reserve of over $19 million and the functions conducted under the Biomonitoring Program are within the scope of expenditure of the fund.

Program Description	Comments
AIDS Drug Assistance Program (May Revise) Through the May Revision, the Department of Public Health has proposed adjustments to the AIDS Drug Assistance Program (ADAP) which are $45.4 million higher than estimated in the Governor's January budget. The May Revision finances the increased ADAP cost from the ADAP Drug Rebate Fund. In the January budget, the Governor proposed 10 percent reductions to both the ADAP and the Therapeutic Monitoring Program which is a companion program to the ADAP in that it is used to measure the effectiveness (through viral load and resistance testing) of certain drug treatment therapies. The reduction to ADAP is $7 million (General Fund) and the reduction to the Therapeutic Monitoring Program is $4.3 million (General Fund), including a current-year reduction.	The Subcommittee discussed the AIDS Drug Assistance Program in detail on April 14th. In addition, fiscal staff has met on a bi-partisan basis with the department to better understand assumptions used for calculating the May Revision update. The department is working to develop a more comprehensive model and they have committed to working with legislative staff regarding this modeling. In addition, the Subcommittee took trailer bill action on April 14th to require the DPH to provide the Legislature with a formal "estimate" package in January and again at the May Revision. Staff Recommendation: It is recommended to (1) adopt the May Revision for the ADAP; (2) backfill the budget balancing reduction of $7 million (General Fund) in ADAP using ADAP Rebate Funds; (3) backfill the budget balancing reduction and current year reduction totaling $4.3 million (General Fund) in the Therapeutic Monitoring Program using ADAP Rebate Funds. These actions would still leave a balance of $43 million in the ADAP Drug Rebate Fund at the end of 2008-09. It is the intent of these actions to conform to the Assembly on these two issues.

4280 Managed Risk Medical Insurance Board—Vote Only Items

Program Description	Comments

4280--Various Managed Risk Medical Insurance Board—Vote Only Items

County Health Initiative Matching Funds Program (May Revise) The May Revision reflects minor funding adjustments to reflect updated estimates submitted by the participating counties (San Francisco, San Mateo, Santa Clara, and Santa Cruz). Specifically, a decrease of $32,000 (County Health Initiative Matching Fund) from the counties is proposed for 2008-09 which results in a decrease of $58,000 in federal matching funds. Therefore, a total of $804,000 (County Health Initiative Matching Fund) is proposed for 2008-09 with almost $1.5 million in federal matching funds to be provided. Assembly Bill 495, Statutes of 2001, allows county governments and public entities to provide local matching funds to claim federal matching funds for their Healthy Kids Programs. No General Fund support is used for this program. (Decrease of $58,000 payable from Item 4280-103-0890 and a decrease of $32,000 payable from Item 4280-103-3055.)	Staff Recommendation: This May Revision adjustment reflects standard caseload and expenditure adjustments. There is no affect on the General Fund from this action. No issues have been raised.

Program Description	Comments
Delay in Implementing SB 487, Statutes of 2006 Pilots (January) The Administration proposes to delay implementation of this legislation for a reduction of $5.230 million ($1.895 million General Fund) in local assistance and a reduction of $333,000 ($116,000 General Fund) in state support. No statutory change is required for the delay of this legislation since implementation is contingent upon appropriation. Among other things, this legislation includes strategies to promote and maximize enrollment in the Medi-Cal Program and the Healthy Families Program (HFP), improve the retention of children already enrolled, and strengthen county-based efforts to enroll eligible children in existing public programs. It also required the Managed Risk Medical Insurance Board to implement processes by which applicants at the time of annual eligibility review may self-certify income rather than provide income documentation. (Decrease of $116,000 in Item 4280-001-0001 and decrease of $217,000 in Item 4280-101-0890 for state support. Decrease of $1.895 million in Item 4280-101-0001 and decrease of $3.335 million in Item 4280-101-0890 for local assistance.)	Staff Recommendation: It is recommended to adopt the Administration's proposal to delay implementation of these projects. This action is consistent with action already taken regarding the Medi-Cal Program. A total reduction of $2.011 million in General Fund support results from this action.

Program Description	Comments
Access for Infants and Mothers (AIM) Program (May Revise) For 2008-09, the May Revision reflects a total annual enrollment of 13,907 pregnant women (monthly average of 1,159 women) in AIM which is a reduction of 1,929 women (reduction in the monthly average of 161 women) as compared to January. The revised estimate assumes total expenditures of $146.6 million ($65.5 million Perinatal Insurance Fund and $81.1 million federal funds) for a reduction of $7.2 million (reduction of $3.3 million Perinatal Insurance Fund and reduction of $3.9 million federal funds) primarily from the caseload adjustment. It should be noted this estimate also reflects an increase in the average one-time capitation rate to $10,468.70 for the budget year, versus the previous amount of $9,641.36. Since the capitation fees vary by plan, the distribution of participants by plan effects the statewide monthly average used in the estimate. The AIM Program provides health insurance coverage to women during pregnancy and up to 60 days postpartum, and covers their infants up to two years of age. Eligibility is limited to families with incomes from 200 to 300 percent of the poverty level. Subscribers pay premiums equal to 2 percent of the family's annual income plus $100 for the infant's second year of coverage. As of July 1, 2004, infants born to AIM women are automatically enrolled in the Healthy Families Program (HFP) at birth, as applicable.	Staff Recommendation: It is recommended to approve the Administration's May Revision for the AIM Program. No issues have been raised. There are no affects to the General Fund from this action. Proposition 99 Funds (Cigarette and Tobacco Product Surtax Funds) are transferred to the Perinatal Insurance Fund for expenditure for the AIM Program as required by existing statute. A portion of these funds are used to obtain federal matching funds through the federal State-Child Health Insurance Program (S-CHIP). (Decrease of $3.891 million in Item 4280-101-0890. Increase transfer authority in Item 4280-111-0232 by $2.087 million. Decrease transfer authority in Item 4280-111-0233 by $1.5 million. Decrease transfer authority in Item 4280-111-0236 by $3.386 million.)

Program Description	Comments

4280-101-0001 Managed Risk Medical Insurance Board—Healthy Families Program

Summary of the Governor's May Revision for the Healthy Families Program. ***(Informational Only)*** *Current Year Update*. The Managed Risk Medical Insurance Board (MRMIB) estimates an increase of $5.6 million ($2.3 million General Fund), or 0.5 percent higher than the Governor's January budget, which represents a $13.7 million ($2.8 million General Fund), or 1.2 percent, *decrease* from the Budget Act of 2007. The reduction in the May Revision for 2007-08 is primarily the result of a 3.1 percent reduction in overall Healthy Families Program enrollment, along with a higher capitation reimbursement compared to the Budget Act of 2007. The lower than expected enrollment is the result of unrealized growth due to fewer applications in total. *Budget Year Update.* The MRMIB proposes total expenditures of $1.078 billion ($389.9 million General Fund, $680.1 million federal funds and $940,000 other funds) for 2008-09. This reflects a reduction of $17.5 million (reduction of $5.9 million General Fund, reduction of $10.6 million federal funds, and reduction of $1.3 million other funds) as compared to the revised current-year estimate. A total caseload of 935,482 children is assumed for 2008-09 which reflects an increase of 54,484 children, or about 6.2 percent, over the current-year. The May Revision assumes implementation of the Governor's reduction proposals as presented in the Special Session, but which were not adopted at that time. These proposals have been adjusted for various reasons, including revised implementation dates, and are assumed to result in a total reduction of $102.1 million ($37.1 million General Fund and $65 million federal funds). Each of these proposals is discussed below.	The Healthy Families Program (HFP) provides subsidized health insurance including dental and vision for children (birth to age 19) in families with incomes from 100 percent of poverty up to 250 percent of poverty. HFP expenditures are funded using 35 percent state General Fund support which draws a 65 percent federal match through a federal allotment obtained under the federal State Children's Health Insurance Program. Subscribers pay monthly premiums and co-payments for services. As required by federal law, children eligible for Medicaid (Medi-Cal in California) must be enrolled in it, and not the HFP. Currently, MRMIB contracts with 21 health plans, 6 dental plans, and 3 vision plans to achieve statewide coverage. The statewide monthly average capitation rate for health, dental and vision plans is $98.91 for children ages 1 to 19 years and $237.17 for children ages 0 to 1 year based upon the May Revision rates. The May Revision issues are discussed on the next pages.

Program Description	Comments
Reduces Healthy Families Program Plan Rates by 5 % (January) The Governor proposes to reduce by 5 percent the rates paid to *all* plans in Healthy Families Program (HFP) for a total reduction of $40.6 million ($14.4 million General Fund and $26.2 million federal funds), as updated for the May Revision. A November 1, 2008 implementation is assumed and the MRMIB states this is contingent upon enactment of statutory changes by July 1. MRMIB contracts with 21 health plans, 6 dental plans, and 3 vision plans to achieve statewide coverage. All of these entities would be affected by the 5 percent rate reduction. The statewide monthly capitation rate is assumed to be $98.91 for ages 1 to 19 and $237.17 for children birth to one based on the May Revision. Plan rates are normally negotiated between January and March and approved by the MRMIB in March of each year for the upcoming budget year. However the MRMIB has postponed certain aspects of this process pending budget actions. This proposal requires: (1) a statutory change; (2) emergency regulation authority; (3) contracts to be re-negotiated with the plans; and (4) a State Plan Amendment which requires federal approval. This proposal interacts with the limit to dental coverage and the proposal to increase copayments, which are both discussed below.	Generally, the Managed Risk Medical Insurance Board (MRMIB) negotiates its Healthy Families Program (HFP) contracts annually and is noted for operating an efficient program. Currently, MRMIB contracts with 21 health plans, 6 dental plans, and 3 vision plans to achieve statewide coverage. All of these entities would be affected by the 5 percent rate reduction. If the 5 percent reduction occurs, there is potential for limited plan choice (i.e., only one plan may be available in some areas), and potential for reduced access to services if a plan needs to limit its network due to the rate reduction. Staff Recommendation: Due to the fiscal crisis, it is recommended to adopt the Governor's 5 percent reduction in rates for all plans participating in the HFP and to adopt placeholder trailer bill legislation for this purpose. It is also recommended to adopt the revised caseload assumptions as contained in the May Revision.

Program Description	Comments
Increase in Healthy Families Program Premiums. (January) The Governor proposes to increase premiums paid by families for enrollment of their children in the HFP as follows: ✓ A. Subscribers from 100-150%. No change. Due to federal cost-sharing requirements, premiums cannot be raised. The premium is $7 per child with a maximum per family of $14 per month. If the "community provider" plan is chosen the premium is $4 per child with a maximum per family of $8. ✓ B. Subscribers from 151-200%. Increase from $9 per child per month to $16, or an increase of $7 per month. The family maximum amount would increase from $27 to $48 per month, or an increase of $21 per month. This is a 77 percent increase. ✓ C. Subscribers over 200%. Increase from $15 per child per month to $19, or by $4 per month. The family maximum amount would increase from $45 to $57 per month, or $12 per month. This is a 27 percent increase. A total reduction of $48.6 million ($18 million General Fund and $30.6 million federal funds) is assumed. This savings level also assumes a reduction of 2.2 percent in caseload due to the premium increases, and families' potential inability to pay. MRMIB notes that the HFP does have "family premium assistance" availability where donations from foundations, the First Five Commission or others can/could contribute to assist families in paying their children's premium. The November 1, 2008 start requires a statutory change, emergency regulation authority, and State Plan Amendment.	Healthy Families Program (HFP) premiums are in statute and must be paid to maintain a child's enrollment. Families with incomes over 200 percent of poverty had their premiums increased as of July 1, 2005 (from $9 to the present $15 per child). HFP does offer subscribers "premium discount options" to offset some costs associated with premiums and co-payments. Discounts offered include (1) $3 per child per month discount for enrollment in a "community provider plan"; (2) subscriber paying 3 months in advance to get one month "free"; and (3) a 25 percent monthly discount for payment of premiums through electronic funds transfer. The Administration's proposal would significantly increase premiums for two categories of family income as noted. Staff Recommendation: It's recommended to **(1)** increase "B" Subscribers *by $4* to be $13 per child, or by 44 percent, with a family maximum of $39; **(2)** increase "C" Subscribers *by $2* to be $17 per child, or by 13 percent, with a family maximum of $51; and **(3)** adopt trailer bill legislation for this purpose. This recommendation would reduce by $38.9 million ($14.5 million General Fund) assuming a November 1, 2008 implementation date and using the same fiscal methodology as the MRMIB.

Program Description	Comments
Increases to Co-Payments for "Non-Preventive" Services in the Healthy Families Program Reflected as Rate Reduction **(January)** The Governor proposes to increase the co-payments of HFP subscribers from $5 to $7.50 for non-preventive services for families with incomes *over* 150 percent (i.e., from 151 to 250 percent). Non-preventive services include, but are not limited to, the following: ✓ Emergency room visits if not hospitalized; ✓ Doctor visits for other than well-child visits, inpatient services or chronic care treatment; ✓ Prescriptions; ✓ Eye Exams and Prescription glasses; ✓ Physical, speech, and occupational therapy; and ✓ Root canals, oral surgery, crowns, bridges, and dentures. The proposed increase of $2.50 in co-payment for each non-preventive service is a 50 percent out-of-pocket increase. This is in *addition* to the monthly premium payments. The May Revision assumes that an increase in co-payments will reduce the utilization of services accessed by children due to the inability of families to pay. Therefore, the May Revision assumes a 1.25 percent rate reduction to health plans due to less services being used. A total reduction of $5.2 million ($1.9 million General Fund and $3.3 million federal funds) is assumed. This proposal requires a statutory change, emergency regulation authority, and State Plan Amendment. No federal approval is needed.	Co-payments are paid by families for most services their children receive, though some preventive services do not require one. Co-payments are in addition to the monthly premiums which families pay. Presently, co-payments for "non-preventive" services are $5 for all HFP children. This proposal would increase co-payments by $2.50, or 50 percent more than paid now, for families *over* 150 percent of poverty. The MRMIB states this amount was selected due to the savings level it achieves. The May Revision assumes that an increase in co-payments will reduce the utilization of services accessed by children due to the inability of families to pay. Therefore, the May Revision assumes a 1.25 percent rate reduction to health plans due to less services being used. Staff Recommendation: It is recommended to reject this proposal. The HFP presently has co-payments, and the HFP Premiums, which are easier to administer than co-payments, are being increased. Further, all plans within the HFP are already having their rates decreased by 5 percent. The Administration's increase in co-payment would reduce the rates paid to health plans by another 1.25 percent.

Program Description	Comments
Proposes To Capitate Dental Coverage in the HFP (January) The Governor proposes to institute an annual limit of $1,000 for dental coverage within the HFP for a total reduction of $8.3 million ($3 million General Fund and $5.3 million federal funds). A November 1, 2008 implementation is assumed. This proposal would limit the annual dental benefit offered to enrolled children to $1,000 annually. Since this proposal reduces total dental benefits, it would reduce dental plan costs, thereby allowing for a reduction in the rates paid to these plans. The HFP presently contracts with 6 dental plans for the provision of dental care services. These plans receive a capitated reimbursement from the HFP based on a defined benefit package and contract rate negotiations. According to MRMIB and their contracted actuary, establishing this dental limit would result in an 8.5 percent rate reduction to dental provider organizations and a 3 percent reduction to dental maintenance organizations. This proposal requires: (1) statutory change; (2) emergency regulation authority; (3) contracts to be re-negotiated with the plans; and (4) a State Plan Amendment. This proposal also interacts with the 5 percent rate reduction issue and the proposal to increase copayments.	The MRMIB states that if the $1,000 cap is imposed, the dental services offered would remain the same until the cap is reach. Therefore, children with multiple dental needs would likely need to spread services over more than one-year. MRMIB's contracted actuary estimates that 5 percent of enrolled children, or about 46,774 children, would reach the proposed $1,000 annual limit in 2008-09. According to MRMIB and their contracted actuary, establishing this dental limit would result in an 8.5 percent rate reduction to dental provider organizations and a 3 percent reduction to dental maintenance organizations. Staff Recommendation: It is recommended to enact a dental coverage limit within the HFP of $1,500 in lieu of the $1,000 cap proposed by the Administration. An effective date of November 1, 2008 is assumed. The $1,500 dental cap would result in a reduction of about $4 million ($1.1 million General Fund) for 2008-09.

Program Description	Comments
Trailer Bill for Vision Benefit Adjustment (May Revision) The MRMIB is proposing new trailer bill legislation to amend Section 12693.65 of the Insurance Code regarding the Vision benefits provided under the Healthy Families Program. Specifically, the proposed amendment is changing the HFP statute to provide for the Vision benefit to no long be "equivalent to" but to instead be "consistent with" those covered benefits provided to state employees. The MRMIB states their intent is to solely address an issue with regards to providing certain types of tinted lenses in eyeglass that are normally used for adult eyewear not children's eyewear as provided under the HFP. MRMIB contends that it would be cost-beneficial to the state to make this change.	Staff Recommendation: Though the intent of the MRMIB is to address a very specific concern with respect to a type of lens, the actual language is rather broad (i.e., "consistent with"). As such, the issue should be discussed and clarified to see if other approaches are warranted.

Program Description	Comments
Reduction to Rural Health Projects within the HFP (May Revision) The May Revision reflects total expenditures of only $2.583 million ($904,000 Proposition 99 Funds—Unallocated Account) for the Rural Health Project within the Healthy Families Program. This funding level for 2008-09 reflects a decrease of about $683,000 as compared to 2007-08. Due to continued declines in Proposition 99 revenues (Cigarette and Tobacco Product Surtax Funds) and increases in certain core caseload-driven programs such as the Access for Infants and Mothers (AIM) Program, the Rural Health Projects have been reduced for the past few years. The Rural Health Projects have been a component of the Healthy Families Program since inception of the HFP in 1998. These projects provide funding for mobile clinics in Northern California, provide assistance to HFP health care plans in rural California, provided dental services and other focused health care access services related to the HFP and provided in rural areas. The Rural Health Projects have been previously evaluated and have successful, measured outcomes.	Staff Recommendation: It is recommended to increase the Rural Health Projects by $960,000 (Proposition 99 Funds—Unallocated Account) and obtain federal funds of $2.7 million for a total *increase* of $3.7 million (total funds). Specifically, it is recommended to shift $960,000 (Proposition 99 Funds--Unallocated Account) within the Department of Public Health used to support the Tobacco Control Program (nine positions) to the Health Education Account within Proposition 99 Funds. The $960,000 within the Unallocated Account made available from this shift would be appropriated to the MRMIB as an increase to the existing Rural Health Projects. MRMIB would then obtain federal Title XXI funds from within the HFP as it presently does for this program. The Department of Public Health's Tobacco Control Program would be funded at the same level using the Health Education Account. The Health Education Account has an unrestricted reserve of $5.9 million available and it is an appropriate use of this account. This unrestricted reserve is in addition to a 5 percent reserve for economic uncertainty.

Program Description	Comments

4260-101-0001 Department of Health Care Services-- Medi-Cal Program

Summary of May Revision for the Medi-Cal Program. ***(Informational Only)*** The Governor's May Revision for 2008-09 proposes total expenditures of $37.2 billion ($413.9 billion General Fund) which reflects a General Fund increase of $315.7 million, as compared to January. General Fund expenditures are expected to decrease by $169.1 million, or 1.2 percent, over the revised 2007-09 level. The average monthly Medi-Cal caseload is expected to increase by 22,900 enrollees, or 0.3 percent, as compared to January. A total of 6.587 million eligibles are estimated for the budget year. Specific issues for the Medi-Cal Program are discussed individually, below.	The federal Medicaid Program (Medi-Cal in California) provides medical benefits to low-income individuals who have no medical insurance or inadequate medical insurance. Generally, California receives a 50 percent match from the federal government for most Medi-Cal Program expenditures. Medi-Cal is at least three programs in one: (1) a source of traditional health insurance coverage for low-income children and some of their parents, (2) a payer for a complex set of acute and long-term care services for the frail elderly and people with developmental disabilities and mental illness, and (3) a wrap-around coverage for low-income Medicare recipients. Generally, Medi-Cal eligibles fall into four categories of low-income people as follows: **(1)** aged, blind or disabled; **(2)** low-income families with children; **(3)** children only; and **(4)** pregnant women. Men and women who are *not* elderly and do not have children or a disability *cannot* qualify for Medi-Cal. Low-income adults without children must rely on county provided indigent health care, employer-based insurance or out-of-pocket expenditures or combinations of these. Medi-Cal eligibility is based upon family relationship, family income level, asset limits, age, citizenship, and California residency status. Other eligibility factors can include medical condition, share-of-cost payments (i.e., spending down to eligibility), and related factors.

Program Description	Comments
Administration's "Unspecified Budget Reduction" (May Revise) In signing the Budget Act of 2007, the Governor vetoed $627.7 million ($331.9 million General Fund) from the Medi-Cal Program for local assistance expenditures. In his veto message it was stated that the reduction was based on historical data showing that on average over the last three fiscal years, Medi-Cal expenditures have been more than $800 million ($400 million General Fund) lower than the Medi-Cal estimate. The veto savings were achieved in the current-year in part through $187 million in lower-than-anticipated caseload costs and enrollee utilization, and in part through $145 million in one-time actions and revised assumptions included in the May Revision. Included in the $145 million is a shift of federal reimbursement for interim public hospital payments from 2008-09 to the current-year, and a delay in General Fund hospital stabilization payments. For 2008-09, the Governor's May Revision includes an "unspecified budget reduction" in the amount of $627.7 million ($323.3 million General Fund) to reflect the continuation of the Governor's veto. The May revision reflects an increase in costs of $17.2 million ($8.6 million General Fund) as compared to January for this assumption. The DHCS states that the Administration intended for the veto to be an on-going reduction in funding the Medi-Cal Program.	The Legislative Analyst's Office (LAO) has raised concerns regarding the Administration's use of an "unspecified budget reduction". First, the LAO recommends an increase of $145 million (General Fund) to recognize that the DHCS is unlikely to realize the full $323.3 million General Fund amount as contained in the May Revision assumption. This augmentation is included in the LAO alternative budget. Second, the LAO recommends adoption of Supplemental Report Language requiring the Department of Finance's Office of State Audits and Evaluations (OSAE) to perform an evaluation of the DHCS Medi-Cal estimate methodology to determine whether improvements can be made to their forecasting methodology that would potentially provide a more accurate prediction of program expenditures. Staff Recommendation: It is recommended to adopt the Administration's May Revision assumption since it appears to be based on an average year-end surplus amount from the last several fiscal years (2003-04 through 2006-07). It should be noted that the $323.3 million General Fund adjustment is in *addition* to all other reduction proposals. Therefore, as the 2008-09 fiscal year progresses, the DHCS may need to re-evaluate the figure based on updated data and assumptions (such as in January 2009 as is normally done).

Program Description	Comments
Eliminate Annual Eligibility & Restore Quarterly Status Reports for Children in Medi-Cal (January Proposal) The Governor proposes to eliminate annual eligibility for children and to instead, require families to submit status reports on a quarterly basis (three times annually plus a re-determination form) or lose Medi-Cal Program enrollment. California is currently among 15 states that offer an annual eligibility for children. A reduction of $79 million ($39.5 million General Fund) is assumed with a September 1, 2008 implementation date (when the quarterly status forms are sent). These savings would be achieved from the disenrollment of 86,026 children from Medi-Cal in 2008-09, primarily for the failure of their families to return a quarterly status report. Children would be dropped from Medi-Cal even if they are still eligible for Medi-Cal. Over time the DHCS states that 471,500 children would likely be disenrolled, or 24 percent of the children required to complete the form. The majority of the children who would be affected by the Administration's quarterly status report are enrolled in Medi-Cal Managed Care plans. Therefore, when children are dropped from Medi-Cal, they would have to be re-processed by the Managed Care plans for enrollment purposes, including choosing a health care plan and network. This change requires: (1) statutory changes; (2) emergency regulations; (3) changes to county eligibility systems; (4) increased county administrative workload; and (5) a Medi-Cal State Plan Amendment.	Currently, children determined eligible for Medi-Cal are enrolled for coverage for one-year (i.e., until an annual re-determination form is submitted). Annual enrollment for children has been in operation for over 7 years. Independent analyses have shown its effectiveness because it assists in assuring, where applicable, uninterrupted health care coverage and provides a medical home for comprehensive coverage (most children are enrolled in Managed Care). Independent analyses have also shown that annual enrollment for children serves to focus limited state dollars on direct health care services versus administrative paperwork and shifting between programs (i.e., Medi-Cal and Healthy Families). The Administration's savings amount does *not* take into consideration increased costs for county administration or processing associated with Medi-Cal Managed Care, or cost shifting between the Medi-Cal and Healthy Families programs. Staff Recommendation: It is recommended to adopt a compromise proposal by implementing *Semi-Annual* Reporting for children. This would result in a reduction of $51.2 million ($25.6 million General Fund) in 2008-09 and assumes 55,800 children are disenrolled by Medi-Cal. This reduction level uses the same calculation methods as the Administration. Placeholder trailer bill language would also be required for this purpose.

Program Description	Comments
Eliminate *Semi-Annual* Eligibility for Parents & Restore Quarterly Status Reports (January Proposal) The Governor proposes to eliminate Semi-Annual eligibility for parents and to instead, require parents to submit status reports on a quarterly basis (three times annually), along with an annual re-determination form, or lose Medi-Cal Program enrollment. A reduction of $7.6 million ($3.8 million General Fund) is assumed with a September 1, 2008 implementation date (when the quarterly status forms are sent). These savings would be achieved from the disenrollment of 6,764 parents from Medi-Cal in 2008-09, primarily for their failure to return a report. Parents would be dropped from Medi-Cal even if they are still eligible for services. A total of 1.162 million parents would have to complete the form. Over time the DHCS states 34,800 parents would likely be disenrolled. The Administration's savings amount does not take into consideration increased costs for county administrative processing or Managed Care enrollment processing. This change requires: (1) statutory changes; (2) emergency regulations; (3) changes to county eligibility systems; (4) increased county administrative workload; and (5) a Medi-Cal State Plan Amendment.	Currently, parents determined eligible for Medi-Cal are enrolled for coverage for six months. They must submit a Semi-Annual status report to continue enrollment for an additional six months. At the one year anniversary of enrollment, parents must submit a comprehensive annual redetermination form to continue enrollment. Families are also required to report any changes in income, assets, and related items *within ten days* during their enrollment period. Semi-Annual reporting for parents has been in use for over 7 years. It assists in assuring, where applicable, uninterrupted health care coverage and serves to focus limited state dollars on direct health care services versus administrative paperwork. Most of these parents are enrolled in Managed Care plans. The Administration's savings amount does not take into consideration increased costs for county administrative processing or Managed Care enrollment processing. Staff Recommendation: It is recommended to reject this proposal and to maintain parents on a Semi-Annual basis. This recommendation corresponds with having children report on a Semi-Annual basis. The policy should be consistent.

Program Description	Comments
Cessation of Payment for Part B Premiums for "Share-of-Cost" Individuals. (January Proposal) The Governor proposes to stop paying the federal Medicare Part B premiums for individuals who are enrolled in Medicare and in Medi-Cal with a "share-of-cost" *and* do *not* meet their Medi-Cal share-of-cost every month. Part B Premiums are for Medicare outpatient costs. A reduction of $53.8 million (General Fund) is assumed with an October 1, 2008 implementation. This savings figure assumes 60,712 individuals, primarily aged and disabled with income above 129 percent of poverty would no longer have their Part B Premiums paid by the state. Instead, the federal Social Security Administration would deduct the Part B Premium from the individual's social security check every month, or the individual could choose not to receive Medicare outpatient services. Specifically, the DHCS would no longer pay the Part B Premiums of about $100 per month since they are not meeting their Medi-Cal monthly share-of-cost requirement. If an individual meets their Medi-Cal share-of-cost requirement, the DHCS would then pay the Part B Premium for the month following the first month that they meet the share-of-cost and continue paying until it is not met. This would be tracked and implemented electronically. Under the Administration's proposal, affected individuals would either need to pay the Part B Premium on their own to maintain the Medicare outpatient services coverage, *or* meet their "share-of-cost" requirement in Medi-Cal for the state to pay the Part B Premium for them. This requires statutory change and notification to the affected individuals.	Generally, the issue at hand is whether the state is reaping any cost-benefit by paying Part B Premiums for certain individuals. Historically, the state has paid Medicare premiums (both "A" and "B") because it was cost-beneficial for the state to do so since it shifted some medical expenditures from Medi-Cal to Medicare (100 percent federally funded). However, the DHCS contends the state does not save General Fund support within Medi-Cal for the payment of Part B Premiums for share-of-cost individuals (as a category). The DHCS states these individuals have an average share-of-cost of over $500 per month and the average outpatient cost for this population is less than $300 per month. This means, on average, the share-of-cost individual would not meet their share-of-cost so the state does not save General Fund when it pays the monthly Part B Premium on a regular basis. This is because the state would pay $100 for the premium but the individual would not be eligible for Medi-Cal and Medi-Cal would not have had to pay for any outpatient services since the share-of-cost was not met. Staff Recommendation: Modify to continue to pay Part B Premiums if individual has a "share-of-cost" *under* $500. A reduction of $48.4 million (General Fund) would be achieved from this action, which is $5.4 million (General Fund) less than the Administration's. Placeholder trailer bill language is also required.

Program Description	Comments
Reduce Medi-Cal Eligibility by Rolling Back 1931 b. (May Revise) Currently, a two-parent family that has earned income under 100 percent of poverty ($1,467 per month, or $17,604 annually, for a family of 3) can apply for 1931 b Medi-Cal enrollment and meet the deprivation test even if the principle wage earner works more than 100 hours per month. The Administration proposes a reduction of $62.3 million ($31.1 million General Fund) by: (1) rolling the income level back to the CalWORKS level—about 68 percent of poverty for 3; *and* (2) reinstating the 100-hour rule, without regard to income, which says the principle wage earner must work *less* than 100 hours per month. A November 1, 2008 implementation date is assumed. The budget year reduction level assumes 104,056 families are not enrolled in Medi-Cal from this action and the annualized level assumes 433,600 people are not enrolled. Most of these individuals would be parents. Children who are dropped would have to re-apply for other Medi-Cal eligibility categories (such as 100 percent of poverty program). The DHCS states their proposal is to affect "applicants" (applying) and not "recipients" (families on CalWORKS or receiving 1931 b Medi-Cal presently). However, if a recipient does not readily return their Medi-Cal status report, they could permanently loose Medi-Cal eligibility if this proposal is enacted. Further, if California did reinstate the 100-hour rule, federal rules dictate that the 100-hour rule would also have to be re-established for people in the Medically Needy Program (another Medi-Cal category). So two-parent families applying for Medi-Cal with the wage earner working more than 100 hours per month would not be eligible for Medi-Cal at *any* income level, not even a "share-of-cost". This requires statutory change and notification to the affected individuals.	This eligibility category was created through the federal Welfare Reform law changes in 1996 which enabled states to grant Medicaid (Medi-Cal) eligibility to families who would have met the income, resource and deprivation rules (such as children with absent, deceased, or unemployed parent) of the old AFDC program as it existed on July 16, 1996. The concept behind this federal policy is to maintain health care for families that leave welfare to work, and to eliminate any incentive to be on welfare in order to receive health care coverage. Under the Administration's proposal, a two-parent family would not meet the income standard for enrollment in Medi-Cal if their income is above the CalWORKS level (68 percent of poverty) and they would not meet the deprivation standard if the wage earner works *more* than 100 hours per month. In essence, this proposal would serve to eliminate two-parent, low-income working families from being enrolled in Medi-Cal. The LAO did *not* include this proposal in their alternative budget. Staff Recommendation: It is recommended to reject this proposal. This proposal serves as a disincentive to two-parent families and as a disincentive to work.

Program Description	Comments
Reduce Medi-Cal Eligibility for "Newly Qualified Immigrants" & "PRUCOL" to "Restricted Services" (May Revise) California law provides legal immigrants with full-scope Medi-Cal services if they otherwise meet all other eligibility requirements. Due to federal law changes in 1996, federal funds are not provided for *non-emergency* Medi-Cal services for immigrants in the U.S. for less than five years. Therefore, $127.8 million in General Fund support would be used for this purpose (i.e., full scope services for adults and children which are *non-emergency*) in 2008-09. There are a total of 90,600 people presently eligible. Effective October 1, 2008, the Administration would restrict Medi-Cal services for "Newly Qualified Immigrants" (about 73,400 people) who have been in the country for less than five years to "restricted-scope" services, versus the full-scope services as presently provided under Medi-Cal. The proposal would *also* implement "restricted-scope" Medi-Cal services for "Permanently Residing Under the Color of Law" (PRUCOL) immigrants and "Amnesty Alien" immigrants who are not defined as eligible "Qualified Aliens" under federal law any more. In addition, these individuals (about 17,200 people) would be placed on the "month-to-month" eligibility cycle as proposed by the Administration (see next issue for more description). A total reduction of $40 million (reduction of $86.7 million General Fund and an increase of $46.7 million federal funds) is assumed from this action. This reduction level assumes the rollback to "restricted-scope" services will reduce present expenditures by 30 percent. It is assumed the remaining 70 percent of the costs will shift to *emergency services* and therefore receive federal matching funds. This proposal requires legislation and data processing changes. No interaction with County Administration is anticipated.	California law has always provided legal immigrants with full-scope Medi-Cal services if they otherwise meet all other eligibility requirements. A total of 90,600 people are presently eligible, within a total of almost 6.6 million eligibles. Of the 90,600 people, about 81 percent, or 73,400 people are "Newly Qualified Immigrants". Of these individuals, 16,900 are children. With respect to individuals with PRUCOL status, there are 17,200 enrollees of which 1,600 are children. Federal law requires states to provide emergency services (with federal financial participation) to immigrants who meet all other Medi-Cal eligibility requirements regardless of immigration status. Restricted-scope Medi-Cal includes emergency services, prenatal care, 60-days of post-partum coverage, and on a very limited basis long-term care. The LAO recommends to reject the Administration's proposal to restrict Medi-Cal services for "New Qualified Immigrants" but to approve the use of "restricted-scope" services for PRUCOL enrollees. The LAO states this action would result in a reduction of $39.7 million (General Fund). The LAO contends that immigrants with PRUCOL status are not any different at the federal level than the status of other undocumented immigrants. Staff Recommendation: It is recommended to reject the Administration's entire proposal.

Program Description	Comments
Establish "Month-to-Month" Eligibility for Immigrants on "Restricted-Scope" Medi-Cal (May Revise) Federal law requires states to provide emergency services (with federal financial participation) to immigrants who meet all other Medi-Cal eligibility requirements regardless of immigration status. In California, immigrants who are not eligible for "full-scope" Medi-Cal because of immigration status receive "restricted-scope" coverage which includes emergency services, prenatal care, 60-days of post-partum care, and on a very limited basis long-term care. "Restricted-scope" Medi-Cal eligibles are subject to Medi-Cal eligibility processing, including redeterminations when applicable. Effective October 2008, the DHCS proposes to limit "restricted-scope" Medi-Cal eligibles, except for pregnancy-related services, to "month-to-month" eligibility during which time the emergency services are received. Eligibility for emergency services, except pregnancy-related services, would begin on the first day of the month in which emergency services are initially needed and end on the last day of the month in which the need for the emergency treatment concludes. The DHCS assumes a reduction of $84 million ($42 million General Fund) in 2008-09 by instituting this "month-to-month" limit. The annualized reduction amount is proposed to be $85 million General Fund. No basis for this estimate has been provided other than it is assumed that this new requirement for "month-to-month" eligibility will reduce expenditures to the 2006-07 level. The reduction assumes 11,000 people will drop enrollment. The DHCS states that $572.5 million (General Fund), along with federal matching funds, will be spent on emergency services for "restricted-scope" Medi-Cal eligibles in 2008-09.	The Medi-Cal Program has a very involved "treatment authorization requirement" (TAR) process. In order for Medi-Cal providers to receive reimbursement from Medi-Cal for treatment of a person on "restricted-scope" Medi-Cal, the provider *must* self-certify that an emergency exists. The DHCS acknowledges they have denied, and do deny, Medi-Cal reimbursement to hospitals and other providers that require prior authorization if certification of an emergency is not provided. All services that require prior authorization are subject to denial. The LAO did not include this proposal in their alternative budget because they could not discern how the reduction as identified by the Administration could be achieved since emergency services need to be provided. Staff Recommendation: It is recommended to reject this proposal. It is unclear how the reduction amount was derived since these are emergency services and require a provider to self-certify. Further, it is unclear how the "month-to-month" would be implemented. For example, is the temporary card good for treatment of a specific episode or condition or what exactly? In addition, the proposal would require hospitals, clinics and others to expand their "out-stationed" eligibility processing workers in order to accommodate the additional paperwork and processing which is not a constructive use of limited-funds.

Program Description	Comments
Governor's Ten Percent Medi-Cal Rate Reduction—Modify? In January, the Governor proposed a 10 percent rate reduction to various providers in the Fee-For-Service Medi-Cal Program, Managed Care Program, and Long-Term Care services, as well as other Medi-Cal services. With few modifications, AB X 3 5, Statutes of 2008, enacts these various reimbursement rate reductions effective as of July 1, 2008. According to the May Revision for Medi-Cal, a reduction of $1.189 billion ($601.1 million General Fund) would occur in 2008-09 from these rate adjustments. If a 5 percent *restoration* was provided to the reimbursement rate reductions as contained in AB X 3 5, Statutes of 2008, an increase of $594.5 million ($300.6 million General Fund) would be required. *In addition*, an increase of $1.8 million ($884,000 General Fund), to provide for a 5 percent rate restoration for Freestanding Pediatric Subacute payments needs to also be included to reflect a proposed adjustment by the Governor at the May Revision. (This way all Subacute entities would be treated in the same manner—i.e., a five percent restoration.) Statutory changes to reflect only a 5 percent rate adjustment would also be necessary. This adjustment should be done equitably in the same manner as the original 10 percent rate reduction. *(Also See Family Health Issues, Item 4260-111-0001, below.)*	.

Program Description	Comments
Multiple Reductions to Medi-Cal Eligibility Work (January) The Administration proposes three reductions in funding provided to County Welfare Departments for Medi-Cal Program eligibility processing. Each would require statutory change to implement. They equate to a total reduction of $152.5 million ($76.2 million General Fund) and are as follows: 1. Eliminates Funds for CA Necessities Index (-$64.6 million total funds). The DHCS would eliminate funds for this 5.26 percent increase in the cost-of-doing-business. Historically the state has provided adjustments to counties to ensure appropriate funding to maintain Medi-Cal eligibility processing staff to meet "county performance measures" as contained in statute, including meeting re-determinations timelines. These "county performance measures" are necessary for California to meet specified federal requirements. California has previously come under scrutiny by the federal government. If a county fails to improve its performance, the DHCS can penalize the county up to 2 percent of its annual Medi-Cal eligibility allocation for the following year. 2. Eliminates Funds for New Caseload Growth (-$41.3 million total funds). The DHCS would eliminate funds for new caseload growth which is historically allocated to counties based on projected Medi-Cal caseload levels. Funds allocated to counties for caseload growth enable them to hire staff to handle increased workload associated with additional people applying for Medi-Cal enrollment. Without this funding, longer waits for Medi-Cal enrollment and health care assistance will occur. Further, it is likely that re-determinations will not be conducted on a timely basis. 3. Reduce "Base Allocation" (-$46.6 million total funds total funds). The DHCS would reduce the "base allocation" by 3.67 percent. This is a backed into reduction figure simply to meet an arbitrary 10 percent reduction. The Administration would have this reduction be on-going.	County Welfare Departments serve as a surrogate for the state in administering Medi-Cal eligibility processing for all individuals applying for Medi-Cal and all aspects of Medi-Cal redeterminations. The accuracy and timeliness of decisions made by eligibility workers are important for maintaining an accurate record of Medi-Cal enrollees (which is tied to the payment of services for providers). Reducing the base allocation would likely result in delays and inaccuracies in eligibility determinations. Not only would this affect individuals trying to enroll, but would affect re-determinations by continuing Medi-Cal eligibility when one may no longer be eligible. The existing methodology used by DHCS to fund counties for caseload growth, as well as salary adjustments, was agreed to after deliberations and was codified in SB 1103, Statutes of 2004. This funding is linked to specific "county performance measures" which saves hundreds of millions in General Fund support annually. This proposal is contrary to this agreement. Staff Recommendation: Due to the fiscal crisis, it is recommended to (1) eliminate $64.6 million ($32.3 million GF) for the CNI-based COLA; and (2) adopt placeholder trailer bill language to suspend the "county performance standard" penalty. It is reasonable to suspend the penalty provisions when funding is not provided. It is further recommended to reject the other two reductions (i.e., for new caseload and the baseline).

Program Description	Comments
Elimination of Adult Dental Services in "Denti-Cal" (January) The Governor proposes to discontinue dental services for adults 21 years of age or older, including pregnant women and individuals with developmental disabilities, effective October 1, 2008. Only adults in nursing facilities would continue to receive services which are federally mandated. Children's dental services are also federally mandated. A total reduction of $147.6 million ($73.8 million General Funds) within the Department of Health Care Services is assumed from this action. However, the elimination of adult dental services, as well as the other nine benefits in Medi-Cal as discussed below, would result in increased expenditures of $11.1 million ($8.3 million General Fund) within the Department of Developmental Services (DDS) to fund clients receiving services through the Regional Centers. The Governor's May Revision reflects this increased cost. The elimination of adult dental services within Medi-Cal requires a change in statute, regulatory changes, and a Medi-Cal State Plan Amendment.	Currently, the Denti-Cal Program provides primary and specialty dental care for adults and children. Adult dental care is provided at the state's option and is not federally required but is federally reimbursed. Six other states besides California provide these services. Denti-Cal operates using strict cost containment requirements. Recent changes include: (1) pre-treatment x-rays to justify restorations; (2) restricted use for certain laboratory processed crowns; (3) increased provider enrollment requirements; (4) reduced payment for periodontal deep cleaning; and (5) an $1,800 annual cap for adult services which sunsets as of January 1, 2009. The DHCS notes that lack of dental treatment often results in emergency room visits which results in a shift to, and increase of, medical and hospitals costs. The LAO has included a reduction of $15 million General Fund in their alternative budget by eliminating root canals and other tooth restorative procedures. Generally, this would result in more teeth extractions. Staff Recommendation: It is recommended to (1) reject the proposal to eliminate adult dental services; (2) adopt placeholder trailer bill language to eliminate the sunset on the $1,800 adult dental cap; and (3) delete the DDS funding as a conforming action.

Program Description	Comments
Elimination of Optometry Services Provided to Adults (January) The Governor proposes to discontinue eye examinations and other vision services performed by optometrists for adults 21 years of age or older that are not in nursing homes. Services provided by ophthalmologists would *not* be affected by this proposal. A total reduction of just over $1 million ($508,300 General Fund) is proposed for 2008-09. An October 1, 2008 implementation date is assumed. This requires a change in statute, regulatory changes and a Medi-Cal State Plan Amendment.	Currently, Medi-Cal provides optometry services, including eye examinations and eyeglasses, as well as diagnostic and ancillary procedures to protect the health of the eye. This coverage also includes medically necessary low vision aids and prosthetic eye services for the visually impaired. This coverage was established in 1971. Optometry services for adults are provided at the state's option and are not federally required but are federally reimbursed. Forty other states besides California provide these services. Services provided by ophthalmologists would *not* be affected by this proposal. There are about 1,200 ophthalmologists and 2,600 optometrists that accept Medi-Cal. Medi-Cal enrollees who are legally blind or visually impaired may require additional assistance from the CA Department of Staff Recommendation: It is recommended to reject this proposal and delete the DDS funding as a conforming action.

Program Description	Comments
Elimination of Optician & Optical Lab Services for Adults (January) The Governor proposes to discontinue optician and optical laboratory services to adults 21 years of age or older that are not in nursing homes. Optician providers dispense prescription eyeglasses and contact lenses prescribed by optometrists and ophthalmologists to Medi-Cal enrollees. Optical laboratory services produce eyeglasses. A total reduction of $7.6 million ($3.8 million General Fund) is proposed for 2008-09. An October 1, 2008 implementation date is assumed. This requires a change in statute, regulatory changes and a Medi-Cal State Plan Amendment.	Currently, Medi-Cal provides Optician and Optical Laboratory services which are used to prescribe, dispense and fabricate eyeglasses. Optician and Optical Laboratory services for adults are provided at the state's option and are not federally required but are federally reimbursed. All fifty states presently provide these services. Federal law requires these services to be provided to children. Without appropriate eyewear, adults in need would have difficulty driving, reading, and conducting other activities of daily living. It should also be noted that the Prison Industry Authority (PIA), under an interagency agreement with the DHCS, fabricates eyewear for Medi-Cal enrollees (at San Diego, Solano, Pelican Bay, and Valley State prisons). PIA was reimbursed $18 million for lens fabrication services in 2006. Staff Recommendation: It is recommended to reject this proposal and delete the DDS funding as a conforming action.

Program Description	Comments
Elimination of Audiology Services for Adults (January) The Governor proposes to discontinue audiology services to adults 21 years of age or older that are not in nursing homes. A total reduction of $3.5 million ($1.7 million General Funds) is proposed for 2008-09. An October 1, 2008 implementation date is assumed. This requires a change in statute, regulatory changes, and a Medi-Cal State Plan Amendment.	Currently, Medi-Cal provides medically necessary audiology services to Medi-Cal enrollees including screening, diagnostic evaluations, hearing aid evaluations, and hearing therapy. These services are provided at the state's option and are not federally required but are federally reimbursed. The bulk of the services are for audiological evolutions for hearing aids. Therefore, this change would also reduce the number of hearing aids and devices provided by Medi-Cal. Without appropriate audiology services, adults in need would have difficulty in hearing and communicating on a daily basis. Staff Recommendation: It is recommended to reject this proposal and delete the DDS funding as a conforming action.

Program Description	Comments
Elimination of Speech Therapy for Adults (January) The Governor proposes to discontinue Speech Therapy services to adults 21 years of age or older that are not in nursing homes. A total reduction of $220,000 ($110,000 General Funds) is proposed for 2008-09. An October 1, 2008 implementation date is assumed. This requires a change in statute, regulatory changes and a Medi-Cal State Plan Amendment.	Currently, Medi-Cal provides medically necessary Speech Therapy services to Medi-Cal enrollees including language evaluation, speech evaluation, therapy, and speech generating device assessment. These services are provided at the state's option and are not federally required but are federally reimbursed. Without appropriate Speech Therapy services, adults in need would have difficulty communicating and being understood on a daily basis. Speech therapy is often an important component for individuals recovering from strokes. Staff Recommendation: It is recommended to reject this proposal and delete the DDS funding as a conforming action.

Program Description	Comments
Elimination of Incontinence Creams and Washes for Adults (January) The Governor proposes to discontinue providing medically necessary incontinence creams and washes to all Medi-Cal enrollees. A total reduction of $5.9 million ($2.9 million General Fund) is proposed for 2008-09. An October 1, 2008 implementation date is assumed. This requires a change in statute, regulatory changes and a Medi-Cal State Plan Amendment.	Currently, Medi-Cal provides incontinence creams and washes to Medi-Cal enrollees, except for children under age five, when these products are determined to be medically necessary. To obtain products, enrollees must have a doctor certify the medical condition that is causing their incontinence and obtain a prescription. These prescriptions can be filled by any Medi-Cal provider (usually a pharmacy or durable medical equipment dealer). Coverage of incontinence supplies was established in 1976. Under the DHCS proposal, enrollees would have to purchase over-the-counter incontinence creams and washes at drug stores and incur the expense. Contracts for incontinence creams and washes signed by the DHCS in November 2007 are estimated to reduce expenditures by $1.3 million (all funds) annually. Staff Recommendation: It is recommended to reject this proposal and delete the DDS funding as a conforming action.

Program Description	Comments
Elimination of Acupuncture Services for Adults (January) The Governor proposes to eliminate Acupuncture Services for adults 21 years of age or older that are not in nursing homes. A total reduction of $2.8 ($1.4 million General Funds) is proposed for 2008-09. An October 1, 2008 implementation date is assumed. This requires a change in statute, regulatory changes and a Medi-Cal State Plan Amendment.	Currently, Medi-Cal provides medically necessary acupuncture services for Medi-Cal enrollees. These services include treatment for pain syndromes and other medical conditions, and are often used for the relief of symptoms of AIDS. Acupuncture services were established as a benefit in the Medi-Cal Program in 1981. These services are provided at the state's option and are not federally required but are federally reimbursed. The DHCS contends that elimination of these services would not increase costs to any other services within the Medi-Cal Program Staff Recommendation: It is recommended to reject this proposal and delete the DDS funding as a conforming action.

Program Description	Comments
Elimination of Podiatry Services for Adults (January) The Governor proposes to eliminate Podiatry services for adults 21 years of age or older that are not in nursing homes. Podiatry services performed by a physician would continue to be reimbursed by Medi-Cal. A total reduction of $1.7 million ($855,000 General Funds) is proposed for 2008-09. An October 1, 2008 implementation date is assumed. This requires a change in statute, regulatory changes and a Medi-Cal State Plan Amendment.	Currently, Medi-Cal provides medically necessary podiatrist services to Medi-Cal enrollees. Podiatry services include medical and surgical services necessary to treat disorders of the feet, ankles, or tendons of the foot rendered by a podiatrist. Most of these services are provided to treat conditions that complicate chronic medical disease, or disorders that significantly impair the ability to walk. These services are provided at the state's option and are not federally required but are federally reimbursed. Coverage of these services in Medi-Cal was established in 1974. California is one of 44 states that offer this benefit. The DHCS states that elimination of these services would increase costs for other services, primarily physician services. These costs have been adjusted for this purpose. Staff Recommendation: It is recommended to reject this proposal and delete the DDS funding as a conforming action.

Program Description	Comments
Elimination of Chiropractor Services for Adults (January) The Governor proposes to eliminate Chiropractor Services for adults 21 years of age or older that are not in nursing homes. A total reduction of $392,000 ($196,000 General Funds) is proposed for 2008-09. An October 1, 2008 implementation date is assumed. This requires a change in statute, regulatory changes, and a Medi-Cal State Plan Amendment.	Currently, Medi-Cal reimburses for medically necessary services provided by a chiropractor. These services include bone and joint manipulation for the relief of pain. California is one of 27 states that offer this benefit. These services are provided at the state's option and are not federally required but are federally reimbursed. Chiropractic services were established as a benefit in 1982. Under the DHCS proposal, enrollees would have to purchase chiropractic services on their own. The DHCS states their savings estimate has been adjusted downward by 25 percent due to anticipated increased costs for physician services which are likely to occur from eliminating chiropractic services. Staff Recommendation: It is recommended to reject this proposal and delete the DDS funding as a conforming action.

Program Description	Comments
Elimination of Psychology Services for Adults (January) The Governor proposes to eliminate Psychology services for adults 21 years of age or older that are not in nursing homes. A total reduction of $189,000 ($95,000 General Fund) is proposed for 2008-09. An October 1, 2008 implementation date is assumed. This requires a change in statute, regulatory changes, and a Medi-Cal State Plan Amendment.	Currently, Medi-Cal provides psychology services to Medi-Cal enrollees under the fee-for-service system. Psychology services include those services provided by, or under the supervision of, a licensed psychologist. These services are restricted to two sessions per month unless provided by County Mental Health Plans (County Mental Health Plans operate under a waiver through the DMH.) These services are provided at the state's option and are not federally required but are federally reimbursed. Psychology services were established as a benefit in 1976, and California is one of 34 states that offer this benefit. This proposal could result in a cost shift to County Mental Health Plans and could result in increased costs due to delays in people obtaining necessary care. Staff Recommendation: It is recommended to reject this proposal and delete the DDS funding as a conforming action.

Program Description	Comments
Proposal for Durable Medical Equipment Contracting (May Revise) The DHCS proposes savings of $1 million ($500,000 General Fund) by pursuing a "pay-for-performance" option for the purchase of durable medical equipment. Under this proposal the DHCS would select a contractor through a competitive process. The contractor would provide specified durable medical equipment and would not be paid by the DHCS until actual savings are realized and validated by the DHCS. No statutory changes are needed for this action. The DHCS has authority to proceed with this proposal and intends to begin the project as of June 2008.	This is a new May Revision proposal from the Administration. This proposal can be implemented administratively. Staff Recommendation: It is recommended to approve the savings amount. No issues have been raised.

Program Description	Comments
Increase Shift of Federal Funds from Public Hospitals to Backfill for General Fund (January) As a result of federal policy changes, California was required to change its method in which designated Safety-Net Hospitals (about 146 hospitals) are financed under the Medi-Cal Program. Senate Bill 1100, Statutes of 2005, provides the state statutory framework for this Hospital Financing Waiver. The Waiver is structured to require Public Hospitals to use their "certified public expenditures" (CPE), in lieu of state General Fund support, to obtain federal funds. This General Fund support was shifted to assist in funding Private and District Hospitals. As such, no state General Fund is used to finance the Public Hospitals as designated in the Waiver. The Waiver is complex and consists of several funding mechanisms, including the "Safety Net Care Pool". The Safety Net Care Pool is a *capped* amount of federal funds that feeds into a series of payments to hospitals which serve a significantly high portion of uninsured people in both outpatient and inpatient settings. The DHCS proposes to shift an *additional* $31.425 million from Public Hospitals and the Safety Net Care Pool to backfill for General Fund support in certain state-operated programs, including the Medically Indigent Adult Long-Term Care Program, the Breast and Cervical Cancer Treatment Program, CA Children Services (CCS) Program, and the Genetically Handicapped Persons Program (GHPP). Presently a total of $44.450 million is used by the state for this purpose. Therefore, the Administration would transfer a total of $75.875 million in federal funds for 2008-09 to backfill for General Fund support. This equates to an annualized amount of $98.650 million The proposed increase of requires a change in statute.	The purpose of the Waiver was to stabilize funding for designated Safety-Net Hospitals and provide for appropriate growth over the course of the 5-year Waiver period. It was structured to maximize California's receipt of federal funds with minimal impact to the state's General Fund. A key concept of this arrangement was to shift General Fund support away from Public Hospitals and to require them to use CPE to obtain federal funds. As such, it is questionable as to whether the Administration's proposal to increase state-operated program support can be implemented and maintained on an annualized basis without threatening the integrity of the overall Waiver. The Administration's proposal would affect access to services by both Medi-Cal enrollees and the uninsured, including Hospital Outpatient services as well as Hospital Inpatient services. California presently uses $44.450 million in federal funds obtained from the Hospital Financing Waiver to backfill for General Fund support in certain programs. Staff Recommendation: It is recommended to reject the additional transfer of $31.425 million and to instead, retain the existing $44.450 million in federal fund transfers which the state is presently using to offset General Fund support. The Administration's proposal would be contrary to the agreement made through the Hospital Financing Wavier with both the federal government and Safety-Net Hospitals.

Program Description	Comments
Administration's Language on Federal Funds in Hospital Financing Waiver—Continuous Appropriation (May Revise) At the May Revision the DHCS has proposed trailer bill legislation to amend Sections 14166.9 and 14166.25 of Welfare and Institutions Code which pertain to the "Demonstration Disproportionate Share Hospital Fund" and the "South Los Angeles Medical Services Preservation Fund". Specifically, the DHCS states that after discussions with the State Controller's Office, state statute needs to be amended that allows for federal funds to be continuously appropriated to these two special funds in order for payments to hospitals to be made under the Hospital Financing Waiver. There is no affect on the General Fund from this action.	The DHCS states this language is needed after discussions with the State Controller's Office (SCO) because there is no statutory authority which allows for the transfer of federal funds from the Federal Trust Fund to these other continuously appropriated funds. The DHCS states they collaborated with the SCO to craft the proposed language and that it is technical in nature. Staff Recommendation: It is recommended to adopt the language so hospitals can appropriately receive payments as provided under the Hospital Financing Waiver. There is no affect on the General Fund from this action.

Program Description	Comments
Reduces Payments for Private Hospitals and District Hospitals (January) The Governor proposes to reduce by 10 percent the amount paid to Private Hospitals and District Hospitals under the state's Hospital Financing Waiver by making adjustments to certain disproportionate share hospital payments, including replacement payments, which are paid to these hospitals. A total reduction of $44.5 million ($22.6 million General Fund) is proposed for 2008-09, as adjusted by the May Revision. This reduction level assumes a July 1, 2008 implementation date. This requires a change in statute.	Under the state's Hospital Financing Waiver, hospitals participating in the Medi-Cal Program receive funds from several sources based on a complex formula. A key aspect of this arrangement is that Public Hospitals receive federal funds based on the use of their certified public expenditures and intergovernmental transfers, whereas Private Hospitals and District Hospitals receive a mixture of state General Fund support and federal funds. This proposal would, in effect, reduce by 10 percent the amount Private Hospitals and District Hospitals receive in disproportionate share hospital replacement payments. Therefore, these hospitals would receive less reimbursement for their uncompensated care costs. Staff Recommendation: It is recommended to reject this proposal. The Administration's proposal would be contrary to the agreement made through the Hospital Financing Wavier with both the federal government and Safety-Net Hospitals.

Program Description	Comments
State's Payment for Fresno Community Medical Center (May) The Administration is proposing an increase of $9 million (General Fund) in Medi-Cal to pay back the federal government due to an impermissible "Intergovernmental Transfer" (IGT) made by Fresno Community Medical Center (a Private Hospital under the Hospital Financing Waiver). Specifically, in 2005-06 the DHCS accepted an IGT from Fresno County in the amount of $18 million to be used as the "non-federal" share of a supplemental Medi-Cal payment to the hospital that was negotiated by the CA Medical Assistance Commission (CMAC). This $18 million IGT was used to draw down federal funds and a payment was made to Fresno Community Medical Center in the amount of $27 million (i.e., $9 million more). The federal government subsequently determined this IGT to be impermissible for a federal match because Fresno Community Medical Center has an annual contract with Fresno County under which it is paid for providing health care to indigent persons and inmates within the county. The funding the hospital would have received in 2005-06 under this contract (i.e., $18 million) was diverted to the DHCS and used as the IGT. This is considered impermissible by the federal government because it is considered a "provider" donation. Based on federal rules, the penalty for an impermissible provider donation is for the state to pay back half the federal funds claimed, or $9 million, to the federal government. According to the DHCS, if the state was to collect the $9 million from the hospital, they would consider the $9 million to be another impermissible provider donation and the state would owe $13.5 million instead of only $9 million. Therefore, the DHCS contends that the only way for the state to rectify the situation is for the state to pay it back and not recover from the Fresno Community Medical Center.	Criteria as to what is considered a permissible Intergovernmental Transfer (IGT) is clearly articulated under the Hospital Financing Waiver and was discussed at length with the federal government and Administration during the negotiations on the Waiver. Due diligence and scrutiny on the part of all parties should have been made regarding this IGT. Staff Recommendation: Due to the fiscal crisis, in lieu of the $9 million General Fund augmentation as proposed by the Administration, it is recommended for the DHCS to use $9 million from within the Private Hospital Supplemental Fund. The Private Hospital Supplemental Fund is a non-federal source of payments made to Private Hospitals under the Hospital Financing Waiver. The fund would be an acceptable source for the state to repay the federal government. It should be noted that there is at least $1 million in *unexpended* money presently available within this Fund.

Program Description	Comments
Limit "Non-Contract" Hospital Rates to Regional CMAC Rate Less Five Percent and Trailer Bill Language **(May Revise)** In the May Revision, the DHCS is proposing to change how Non-Contract Hospitals are to be reimbursed under Medi-Cal. This action requires statutory changes and would be effective October 2008. About 144 Non-Contract Hospitals would be affected by this change. Rural hospitals, as defined in existing law, are *exempt* (about 66 hospitals) from this proposal. Currently, Non-Contract Hospitals are paid generally at cost. AB X3 5, Statutes of 2008, included the Governor's 10 percent Medi-Cal rate reduction effective as of July 1, 2008. This is estimated to save $54.2 million (total funds) in 2008-09. Rural hospitals are included in this 10 percent action. The May Revision would change statute to reimburse Non-Contract Hospitals, *except* Rural Hospitals, to the *lower of:* **(1)** the interim per diem rate minus 10 percent as is in effect on July 1, 2008; **(2)** the "regional" average per diem CMAC contract rate for Non-Tertiary Hospitals minus 5 percent; *or* **(3)** a statewide rate for Tertiary Hospitals, as defined, minus 5 percent. It is assumed that an *additional* $22.5 million ($11.2 million General Fund) in savings would be achieved from this action. The DHCS states their calculation uses the most recent public hospital rates from CMAC (i.e., rates public after 3 years), and accounts for trending factors to bring these rates current. The rates are based on the three geographic regions CMAC uses, as well as Tertiary Hospital rates. The DHCS proposes these changes due to concerns with maintaining a viable and effective Selective Provider Contracting Program closures. In essence, Non-Contract hospitals need to be encouraged to contract.	About 200 hospitals participate in the Selective Provider Contracting Program as administered by the DHCS and negotiated by the CA Medical Assistance Commission (CMAC). CMAC negotiates per diem rates and supplemental payment amounts for contract hospitals on a competitive basis. This program has been cost-beneficial to the state. However, the DHCS states that inpatient hospital contract rates have increased by 4.3 percent annually in the last five years, which is a faster rate than in the Medicare Program. Some of this increase is due to less competition and hospital closures, as well as higher reimbursement rates presently paid to Non-Contract Hospitals. Non-Contract hospitals do *not* contract with CMAC. Non-Contract Hospitals are paid an interim rate that approximates their reimbursable costs and is *subject* to settlement based on a DHCS audit. Staff Recommendation: It is recommended to: (1) adopt the May Revision reduction of $22.5 million ($11.2 million General Fund); and (2) adopt placeholder trailer bill language with the intent to send to Budget Conference Committee to continue discussions and fine tuning.

Program Description	Comments
Trailer Bill Legislation—Reduce Certain Hospital Rates for Medi-Cal Managed Care Plans (May Revise) Through the May Revision the DHCS is proposing new statute through trailer bill legislation that limits the amount Medi-Cal Managed Care health plans must pay hospitals that refuse to contract with them. No fiscal adjustments are proposed for 2008-09 from this proposed statutory change. The DHCS states this language will serve three purposes: (1) it provides an incentive for hospitals to enter into contracts with Medi-Cal Managed Care plans; (2) it will reduce the costs that health plans pay to Non-Contract Hospitals; and (3) the limitations imposed for emergency inpatient services will fully comply with the federal Deficit Reduction Act (as articulated in the "Rogers Amendment"). The proposed language would be effective as of October 1, 2008. Though no savings are identified in 2008-09 from the DHCS' proposed statutory changes, they state that all outcomes from this proposal serve to contain or limit growth of hospital costs for Medi-Cal Managed Care plans, thereby reducing pressure on capitation rates and General Fund expenditures. Further, the DHCS notes that if this proposal is enacted, actuaries will factor this into the rate development process. The Administration states that this proposed trailer bill language is a companion piece to the Non-Contracting Hospital language (above in this Agenda) with the central theme being to encourage participation in the Medi-Cal Program through state contracting and Medi-Cal Managed Care arrangements.	Generally, a provision of the federal Deficit Reduction Act (Section 6085—known as the "Rodgers Act") capped rates for non-contracted emergency services for Medicaid (Medi-Cal) Managed Care plans at a state's Fee-for-Service schedule. The intent of this section was to promote responsible utilization of emergency services, provide reasonable payment to hospitals, and encourage quality health plans to participate in Medicaid (Medi-Cal). The DHCS states their proposed trailer bill language conforms to the "Rodgers Act" as it pertains to emergency services and hospital payment. In addition, the DHCS proposal goes *one step further* by intervening in hospital rates for post-stabilization services which would be reimbursed on a methodology that is the regional rate minus 5 percent. Hospital constituency groups have expressed concerns with this proposal, while other interested parties like the concept of the proposal but require further discussions on actual language and the mechanics of how it may work. Staff Recommendation: It is recommended to adopt placeholder trailer bill language in concept only to continue discussions with all interested parties, including Medi-Cal Managed Care plans, the hospitals, the DHCS and other interested parties. By this action it is the intent of the Committee to send this issue to the Budget Conference Committee for deliberation.

Program Description	Comments
AB 1629 Nursing Homes & Trailer Bill (May Revise) First, the May Revision provides an increase of $44.8 million ($22.4 million General Fund) as compared to January due to a revised estimate of the August 2008 cost-of-living-adjustment. This estimate is based on cost reports received from nursing homes (Level B Nursing Homes) and then calculated by the DHCS according to existing rate methodology as contained in AB 1629, Statutes of 2004. Specifically, the May Revision reflects a COLA adjustment of 4.9 percent, as compared to January which reflected a 3.4 percent increase. The higher cost growth reflects the increases in the actual cost reports and the necessary rate increases as provided under the methodology. The estimated increase is within the existing statutory 5.5 percent rate cap. A total increase of $147.3 million ($73.6 million General Fund) is proposed in 2008-09 for these facilities. Second, the DHCS proposes trailer bill language to (1) extend for *two years* the sunset date for this rate methodology to until the 2010-2011 rate year; (2) capitate the maximum annual increase to 5 percent for 2009-10 and 2010-2011; (3) convene a stakeholder process to make recommendations to the DHCS regarding the rate methodology and quality assurance issues; and (4) require the DHCS to provide to the Legislature by October 1, 2009 the complete recommendations of the workgroup members and the department's analysis of the feasibility of implementing the recommendations. The DHCS contends a two-year extension is necessary in order to have a meaningful process for future recommendations. Further, the cap of 5 percent reflects the original level as contained in the enabling legislation.	The purpose of this enabling legislation was to create a *"facility-specific"* reimbursement methodology for nursing homes, and to authorize a provider *"Quality Assurance Fee"* to assist in providing a Medi-Cal rate increase. The purpose of these changes were to: (1) encouraged access to appropriate long-term care services; (2) enhanced quality of care; (3) provided appropriate wages and benefits for nursing home workers; and (4) encouraged provider compliance with state and federal requirements. The Administration has yet to conduct a comprehensive analysis of the effects of the rate increases and only recently convened in May 2008 a stakeholder meeting to discuss quality assurance measures. Existing statute continues the rate methodology through to July 31, 2009. This statute was initially scheduled to sunset on July 31, 2008 but was extended through trailer bill legislation (AB 203, Statutes of 2007). Staff Recommendation: The following are proposed: (1) approve the May Revision fiscal estimate; (2) approve the DHCS' five percent cap going forward to be fiscally prudent, and provide for a two-year extension; (3) require the DHCS to expedite its process and provide information to the Legislature by no later than February 1, 2009; and (4) require the DPH's report on outcomes data in Section 14126.033, W&I Code, to include three years of data (not two), including most recent 2007-08 data. This would provide for a policy deliberation process and facilitate the implementation of quality assurance..measures.

Program Description	Comments
Adjustments to Medi-Cal Managed Care (May Revise) The May Revision proposes several adjustments to the funding provided to Managed Care plans participating in the Medi-Cal Program. These adjustments include the following key items: • Increased Funding for Additional Enrollees. An increase of $100.5 million (total funds) is proposed to reflect an increase of 37,608 enrollees. This funding is based on methodology as contained in statute and newly implemented this year. • Includes a Deferral of Hold Harmless Payment. Includes $38.5 million (total funds) to account for a deferral of a payment from 2007-08 to 2008-09 to hold certain plans harmless for one-year due to the rate changes implemented in statute. • Continues Actuarial Rate Equivalent of 10 % Reduction. Includes a decrease of $382.1 million (total funds) to reflect the Governor's rate reduction as adopted in Special Session. • Reflects Rate Increase Based on Methodology. Includes an increase of $278.2 million (total funds) to reflect the new rate methodology which uses experienced-based, plan-specific data.	Concerns from constituency groups regarding a lack of clarity regarding how the DHCS builds the Medi-Cal Managed Care rate, and when plans are informed of their actual rates, have been previously expressed. In addition, the Geographic Managed Care Plans within the Medi-Cal Program remain to be the only plans under the auspices of the CA Medical Assistance Commission (CMAC). Consideration should be given to having the rates of all plans under the DHCS for clarity and consistency. Staff Recommendation: It is recommended to (1) approve the May Revision fiscal estimate; (2) adopt placeholder trailer bill language to move the GMC Plans reimbursement for Medi-Cal under the DHCS; and (3) adopt placeholder trailer bill language regarding the future structure of the CA Medical Assistance Commission. Further, the Committee may want to consider trailer bill language to require the DHCS provide at least preliminary or interim Managed Care rate information on a per-plan basis in a more open and timely fashion.

Program Description	Comments
Reduces by 10 Percent Medi-Cal Funding for County CCS Program Staff and Administration (January) The DHCS reduces by 10 percent Medi-Cal administrative funds used to support case management functions conducted by County California Children's Services (CCS) staff, including eligibility processing, making medical necessity determinations, and authorizing specialized medical services for children. The DHCS states this reduction to County CCS Programs will likely affect processing times for eligibility determinations, determining medical necessary services, and authorizing services. The total proposed reduction is $6.8 million ($2.2 million), accounting for May Revision adjustments. This program receives an enhanced federal match level due to the use of clinical staff. This requires a change in statute and emergency regulations. A July 1, 2008 implementation date is assumed	The CCS Program is the oldest managed health care program in the state and the only one focused specifically on children with special health care needs. It depends on a network of specialty physicians, therapists and hospitals to provide this medical care. By law, CCS services are provided as a separate and distinct medical treatment (i.e., carved-out service). County CCS staff is critical to the overall functioning of the CCS Program. Due to the medical necessity aspect of the program, counties must conduct a financial eligibility process for the children, as well as make a medical eligibility determination. This *initial* processing of new cases requires a review of financial documentation, reviews of medical charts, identification of service providers and assistance in appointment making. County CCS staff is also responsible for processing medical service treatment authorizations. As such service delays may result in increased use of emergency rooms for unmet medical needs Staff Recommendation: It is recommended to reject this proposal. As noted by the DHCS, it is likely this reduction would directly affect access to very critical CCS Program services for medically needy children.

Program Description	Comments
Trailer Bill Language—Contract for Blood Factor (May Revise) Through the May Revision, the DHCS is proposing trailer bill language to enter into exclusive or nonexclusive contracts on a bid or negotiated basis to contract with providers licensed to distribute specialty pharmaceuticals, including suppliers that provide blood, blood derivatives, or blood factor products. It should be noted that other *specialty drugs* as identified by the DHCS would also be included in this proposal, including immunizations. The DHCS is seeking to conduct these efforts under the Medi-Cal Program, California Children's Services (CCS) Program and Genetically Handicapped Persons Program (GHPP). The proposed language does provide for the DHCS to contract with an intermediary to establish provider contracts (such as a pharmacy benefit manager for example). The DHCS states they are seeking this trailer bill language to begin a process to work with the industry and constituency groups, including individuals with Hemophilia and similar conducts who may utilize these products, in an effort to (1) provide better cost-management and oversight; and (2) ensure proper patient care. No fiscal reductions or costs are associated with this proposal for 2008-09. The DHCS does not intend to implement any process before June 2009.	Clearly, specialty drug pharmacy contracting would be a new venture for the DHCS to administer. As noted by the types of biologic products and very specialized drugs referenced, this is an extremely medically involved area. As such, it is imperative that proper patient care be address, that existing products are available and that a network of pharmacies be used to ensure timely and appropriate access to products. Staff Recommendation: It is recommended to adopt placeholder trailer bill legislation that would (1) contain a three-year sunset to enable a review; (2) delete *any* reference to exclusive contracts; (3) provide for consumer quality of care factors; (4) ensure a network of pharmacies; and (5) make it clear that blood factor product choice will not be limited.

Program Description	Comments
Trailer Bill Language for Supplemental Rebates for Coagulation (Blood) Factor (May Revise) Through May Revision the DHCS is proposing trailer bill language to require the manufacturers of FDA-approved coagulation factors to pay a supplemental rebate for products dispensed to individuals in the Medi-Cal Program and DHCS administered Waiver programs. The DHCS assumes initial savings of $522,000 ($261,000 General Fund) from collection of these supplemental rebates. An effective date of July 1, 2008 is assumed. The DHCS states that this would allow contracts to be completed by the first quarter of 2009 and initial rebates would be received in June 2009.	Concerns from some manufacturers of coagulation factor have expressed concerns with this DHCS proposal trailer bill language. Staff Recommendation: It is recommended to (1) adopt placeholder trailer bill language; and (2) adopt the proposed savings level for Medi-Cal due to the collection of supplemental rebates.

Program Description	Comments
Administration's Proposed Trailer Bill Language on Provider Information (May Revise) The DHCS is proposing trailer bill language which would provide the DHCS with broad discretion as to how the DHCS chooses to notify providers regarding implementing changes in the level of funding for health care services (i.e., the Medi-Cal Program, CA Children's Services Program, Genetically Handicapped Persons Program and all other DHCS-administered programs). Specifically, the proposed statutory change is as follows: "Notwithstanding any other provision of law, in order to implement changes in the level of funding for health care services, the department *may* distribute provider bulletins and other provider communications by either print or electronic medium, including posting on the department's Web site. Posting on the department's Web site shall constitute full and complete notice to providers of information relating to Medi-Cal, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), Family PACT, and the Every Women Counts Program, including *any* changes to these programs. This section shall be implemented on the first day of the month following 90-days after the operative date of this section." The DHCS assumes a reduction of $2 million ($1 million General Fund) from this action; however no detail has been provided regarding the full basis of this savings level.	The proposed trailer bill legislation is very broad and would enable the DHCS to skirt appropriate public notification and process, including the implementation of regulations for making *any* program changes. Providers who participate in the state's health care programs should be given appropriate, professional and business-like notification regarding changes to the state's reimbursement policies or program operations. Declaring that by posting information on a department Web site constitutes full and complete notice is questionable, particularly given difficulties one can incur in even navigating the existing DHCS Web site as experienced by legislative staff. Staff Recommendation: It is recommended to reject the proposal trailer bill language and to reject the assumption that $2 million ($1 million General Fund) can be obtained from this proposal. This is broad language with a strong intent to avoid public notice requirements and potentially the regulatory process.

Program Description	Comments

4260-111-0001 Department of Health Care Services--- Family Health Programs

Governor's Ten Percent Rate Reduction—Modify? In January, the Governor proposed a 10 percent rate reduction to various providers in the California Children's Services Program, CHDP, and the Genetically Handicapped Persons Program since these family health programs utilize the Medi-Cal Program reimbursement rate methodology. AB X 3 5, Statutes of 2008, enacts these various reimbursement rate reductions effective as of July 1, 2008. If a 5 percent *restoration* was provided to the reimbursement rate for these programs, an increase of $10.1 million ($5.2 million General Fund) would be required. Statutory changes to reflect only a 5 percent rate adjustment would also be necessary.	

Program Description	Comments
May Revision Adjustments & Senate Conforming Action for the CA Children's Services Program (CCS) (May Revise) The May Revision for the CA Children's Services (CCS) Program proposes total expenditures of $241.5 million ($84.9 million General Fund) for an increase of $3.325 million (increase of $6 million General Fund) as compared to January. The May Revision includes a series of technical fiscal adjustments for caseload and utilization, as well as the: (1) ten percent rate reduction; (2) a ten percent reduction to "medical therapy" services; (3) an increase of $15.962 million (federal Safety Net Care Pool) to offset General Fund support; and (4) a reduction of $483,000 (General Fund) to reflect a 10 percent to CCS case management to parallel the Medi-Cal Program. (Please note the 10 percent rate issue was addressed in this Agenda, above.)	Staff Recommendation: Adopt a series of actions for the CCS Program. These adjustments recognize technical caseload and utilization cost updates (baseline adjustments) as contained in the May Revision, conform to Medi-Cal Program actions, and address other CCS issues. Actions are as follows: • Adopt caseload and baseline adjustments for the CCS Program as contained in the May Revision. • Reject the 10 percent reduction for CCS Program case management for an increase of $1.3 million ($483,000 General Fund and $817,000 federal Title XX). This conforms to the prior action in Medi-Cal regarding the rejection of the 10 percent CCS Program case management. • Reject May Revision to reduce CCS medical therapy services by 10 percent for a reduction of $3.074 million (General Fund). *Instead*, reduce by only 5 percent and provide a $1.537 million restoration using $1 million in federal Title V Maternal and Child Health Funds and $537,000 in General Fund. The federal Title V Maternal and Child Health Funds are from the reserve within the Department of Public Health (DPH). (The DPH will transfer this reserve to the DHCS.) • Increase by $15.962 million General Fund to reflect a conforming action with Medi-Cal to not use additional Safety Net Care Pool Funds from the Hospital Financing Waiver.

Program Description	Comments
Genetically Handicapped Persons Program (May Revise) The May Revision for the Genetically Handicapped Persons Program (GHPP) proposes total expenditures of $69.6 million ($47.5 million General Fund) for 2008-09 for an increase of $23 million ($19.5 million General Fund) as compared to January. The May Revision includes a series of technical fiscal adjustments for caseload and utilization, as well as: (1) a reduction of $4.7 million (General Fund) to reflect the ten percent rate reduction; (2) a reduction of $4.4 million (General Fund) to reflect *existing* blood factor rebates and contract savings; and (3) an increase of $9.415 million (federal Safety Net Care Pool) to offset General Fund support. The May Revision for the GHPP does *not* reflect any reductions or adjustments related to the DHCS trailer bill language regarding (1) blood factor contracting; or (2) new blood factor rebates. (Please note the 10 percent rate issue was addressed in this Agenda, above.)	Staff Recommendation: Adopt the following adjustments: • Adopt caseload and baseline adjustments for the GHPP as contained in the May Revision. • Increase by $9.415 million General Fund to reflect a conforming action with Medi-Cal to not use *additional* Safety Net Care Pool Funds from the Hospital Financing Waiver.